Medi-Cal Provider Enrollment
Frequently Asked Questions

In order to facilitate easier access, frequently asked questions are organized and listed under the following topics. Links to Department of Health Care Services (DHCS) Web sites are provided within the answers.

Provider enrollment bulletins are issued based on the authority granted to the director of the DHCS in the *Welfare & Institutions Code*, Section 14043.75(b) that have the full force and effect of law.

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ENROLLMENT REQUIREMENTS

1. Where do applicants find information regarding enrollment requirements?

For information regarding provider enrollment, please refer to the **Statutes, Regulations, and Provider Bulletins** section of the Provider Enrollment page.

Applicants and providers are encouraged to review the forms and enrollment regulations available on the Medi-Cal Web site. The regulations contain guidance on how to apply for the Medi-Cal program, application criteria and terminology, processing timelines, and the requirements for participation in the Medi-Cal program.

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2. How do providers report a change in their enrollment information?

A provider is responsible for notifying DHCS within 35 days of any change to previously submitted information as listed below.

- Effective July 1, 2008, a *Medi-Cal Change of Location Form For Individual Physician Practices Relocating Within the Same County* (DHCS 9096) may be submitted by a currently enrolled individual physician or osteopath for a change in business location within the same county. The form shall be subject to the same review outcomes as a complete application package. Failure to submit an application when there is a change in the business location may result in returned payments for services and potential disenrollment of the provider number.
- Except as stated above, for a change in business location or to add an additional location, a new complete application package must be submitted for approval of the new service address and to update the Provider Master File. Failure to do so will result in returned payments for services and potential deactivation of the provider number.
- To report a change to a provider's business entity, i.e., change from sole proprietor to a corporation or a partnership, a new complete application package is required.
- A change in **ownership of 50 percent or more** requires a new complete enrollment application consisting of either the *Medi-Cal Physician Application/Agreement* (DHCS 6210) or the *Medi-Cal Provider Application* (DHCS 6204), depending upon the type of provider enrolling, along with a *Medi-Cal Provider Agreement* (DHCS 6208), *Medi-Cal Disclosure Statement* (DHCS 6207), and all required attachments.
- If the entity changing ownership is enrolled as a group, the applicant is required to submit a *Medi-Cal Provider Group Application* (DHCS 6203).

To report any other changes, please refer to the items listed on the *Medi-Cal Supplemental Changes* form (DHCS 6209) form.

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3. What are the enrollment requirements when a *Successor Liability with Joint and Several Liability Agreement* (DHCS 6217) has been completed?

A provider number is not transferable pursuant to Title 22, CCR Section 51000.52 (b), except when a transferee applicant meets the successor liability with joint and several liability requirements set forth in Title 22, CCR Section 51000.32. Therefore, without completion of the agreement, the transferor (seller) remains solely liable after the close of the sale, until such time that the transferee (buyer) becomes an enrolled provider. Should the buyer subsequently fail to become enrolled as a Medi-Cal provider, the seller continues to solely carry all liability to DHCS for all amounts paid for services, goods, supplies, or merchandise, provided directly or indirectly, to Medi-Cal beneficiaries**.**

Upon the sale or transfer of a Medi-Cal enrolled business, and when a transferor (seller) elects to complete a *Successor Liability with Joint and Several Liability Agreement*, the transferee (buyer) must submit a complete application package to DHCS within 35 days of the occurrence of a circumstance listed below:

(1) A sale or transfer of 50 percent or more of the assets owned by the corporation at the location for which a provider number was issued;

(2) A cumulative change in the person(s) with an ownership or control interest of 50 percent or more that has occurred since the information provided in the last complete application package approved for enrollment;

(3) When a new Taxpayer Identification Number is issued by the Internal Revenue Service (IRS);

(4) When the Board of Pharmacy requires a new site permit, pursuant to Chapter 9 (commencing with Section 4000) Division 2 of the Business and Professions Code;

(5) A change of ownership as defined in Title 22, CCR Section 51000.6.

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4. What has changed regarding enrollment application requirements as a result of National Provider Identifier (NPI) implementation?

Effective May 23, 2007, applicants/providers are required to submit their NPI with each Medi-Cal application package. Applicants must submit verification of each NPI submitted to DHCS in an application package, including the *Medi-Cal Supplemental Changes* form, if appropriate. This verification is required each time an applicant or provider submits an application or *Medi-Cal Supplemental Changes* form for each NPI application.

Acceptable confirmation includes:

(1) NPI notification letter from the National Plan and Provider Enumerator System (NPPES);

(2) NPI notification e-mail from NPPES, or;

(3) NPI notification from the Electronic File Interchange Organization via letter or e-mail.

If providers are not eligible to receive an NPI, they are not required to submit an NPI and should instead enter the word "atypical" in the NPI field.

For more information on the NPI, please refer to **NPI: FAQs**:

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APPLICATION PACKAGE AND PROCESSING

1. How do applicants enroll in Medi-Cal?

To enroll as a Medi-Cal provider, the appropriate application package must be submitted for the appropriate provider type. For a listing of the required forms by provider type, please refer to the ***New to Medi-Cal Provider Application Reference Chart***.

- To request an application form, please contact the fiscal intermediary, Electronic Data Systems (EDS), Telephone Service Center at 1-800-541-5555.
- Download application forms from the **Application Forms** section of the Provider Enrollment page on the Medi-Cal Web site (**www.medi-cal.ca.gov**).

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2. How do physicians who are new to Medi-Cal request to join a group? What forms are required?

- Physicians who are new to Medi-Cal and are joining a group must submit the *Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers* (DHCS 6216).
- Providers with an active Medi-Cal provider number are **not** required to submit an application when joining an enrolled group.

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3. Who should an applicant contact to answer questions about completing the application?

An applicant may contact the Telephone Service Center at 1-800-541-5555, the Provider Enrollment Message Center at (916) 323-1945 or submit written question(s) to the Department of Health Care Services, Provider Enrollment Division, MS 4704, P.O. Box 997412, Sacramento, CA 95899-7412. The DHCS can assist applicants by providing guidance on what forms to complete but is not able to provide advisory opinions regarding completion of applications. The DHCS is specifically prohibited by law from answering questions about interpreting the statutes or regulations and can only cite the statutes and regulations themselves.

To obtain information on the statutory and regulatory requirements for participation in the Medi-Cal program, please refer to the **Statutes, Regulations, and Provider Bulletins** section of the Provider Enrollment page.
If unclear about how to interpret Medi-Cal instructions or regulations, please contact your legal counsel for assistance.

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4. What are the different address types and how are they used?

The application requests a business, pay-to, and mailing address. This information is used as follows:

- The **business** address is the physical location where services will be rendered. General correspondence will be mailed to this address. Post office or commercial boxes are **not** acceptable.
- The **pay-to** address is the address at which the provider wishes to receive payment for services. Post office or commercial boxes are acceptable.
- The **mailing** address is the address at which the provider wishes to receive the "Welcome To Medi-Cal" package, which includes the assigned Provider Identification Number, and the on-going monthly bulletins. Post office or commercial boxes are acceptable.

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5. How does a non-profit entity complete the *Medi-Cal Disclosure Statement* (DHCS 6207)?

Most non-profit organizations are run by a governing board (e.g., Board of Directors). As such, each member of the applicable governing board must be reported. Additionally, although the vast majority of non-profit organizations do not have owners, any individual who owns at least 5 percent of the non-profit organization must be reported.

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6. Who can sign the application?

The application must be signed under penalty of perjury by an individual who is the sole proprietor, partner, corporate officer or an official representative of a governmental entity or non-profit organization, and who has the authority to legally bind the applicant seeking enrollment as a Medi-Cal provider.

Applications must have original signatures.

- Stamped, faxed or copied signatures are **not** acceptable.
- A photocopy of the application submitted with an original signature is acceptable.
- It is unlawful to alter a photocopied application in any manner.
- A biller or office manager is **not** a valid signatory.

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7. Where do applicants mail the application?

Completed forms should be mailed to:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P. O. Box 997412
Sacramento, CA 95899-7412

NOTE: Provider Enrollment staff cannot meet with individual applicants. An application cannot be delivered in person to the DHCS.

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8. How long does it take to process the application?

Applications are reviewed and processed in accordance with Medi-Cal provider enrollment statutes. The review of an applicant's or provider's application package is a complex process that requires assessment of many elements of the application, including a review of the required supporting documentation, to determine eligibility for enrollment into the Medi-Cal program. The DHCS may conduct a background check of an applicant or provider for the purpose of verifying information. This background check may include an unannounced onsite inspection, a review of business records and data searches to ensure that the applicant or provider meets enrollment criteria.

Effective July 1, 2008, DHCS shall provide written notice confirming receipt of an application package from a physician or a physician group within 15 days. For applications from provider types other than physicians or physician groups, a written notice confirming receipt will be mailed within 30 days. This letter also may notify applicants whether a moratorium exists on the provider type.

Effective July 1, 2008, applicants will be notified in writing of one of the items listed below within 90 days of receiving an application from a physician or physician group. Notification to applicants other than a physician or physician group remains at 180 days.

The application is approved for enrollment as a provisional provider;

- The application is incomplete and additional information is required;
- The application is referred for a comprehensive review and background check; or
- The application is denied with the reason(s) for denial.

Effective July 1, 2008, "Preferred" provider applications are statutorily required to be processed in 60 days if all the required documentation is submitted. If all appropriate documentation is not submitted, the application may take up to 90 days to process. For information regarding the criteria for "preferred provider status" on our Web site, refer to the ***Medi-Cal Provider Enrollment Preferred Provider Status*** article available on the Provider Enrollment page.

Effective July 1, 2008, DHCS shall notify an applicant within 15 days of receipt of a *Medi-Cal Hospital-Based Physician Application/Disclosure Statement/Agreement* (DHCS 9095). Within 90 days, DHCS shall notify the applicant of approval or notify the applicant that the applicant does not meet the required criteria. For more information on the criteria, refer to the ***AB 1226 – Provider Enrollment Forms & Provisions Effective July 1, 2008*** article on the Medi-Cal Web site.

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9. What happens if applicants submit an incomplete application?

Incomplete applications will be returned to the applicant with an explanation of what information is missing, and requesting that these items be submitted within the 60-day statutory requirement.

- If a corrected application is returned to the DHCS within the 60 days of the notice, processing continues.
- Within 60 days of receipt of the resubmitted application, notification of approved enrollment, referral for comprehensive review and background check or denial is mailed to the applicant or provider to the service address or business address listed on the application.
- After July 1, 2008, if an application from a physician or physician group is not returned within the 60-day timeframe, the resubmitted application will be treated as a new application and the 90-day application processing process starts over again.

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10. Can applicants check the status of their application?

If applicants do not receive an acknowledgement of receipt letter from the DHCS within the timeframe specified in FAQ #8 above, they may contact the Provider Enrollment Message Center, (916) 323-1945, or submit their inquiry, in writing, via e-mail a **PEDCorr@dhcs.ca.gov** or to the address listed below:

Department of Health Care Services
Provider Enrollment Division
MS 4704
P. O. Box 997412
Sacramento, CA 95899-7412

In order to conduct research efficiently, please include the provider's name and medical license number, social security number and/or tax identification number. If possible, please also include a copy of the acknowledgement of receipt letter from the Provider Enrollment Division (PED) showing the document tracking number assigned to the application.

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11. How are applicants notified of their application approval or disapproval?

New to Medi-Cal individual and group providers receive a "Welcome To Medi-Cal" letter, which includes the enrolled provider number (NPI) and the effective date of enrollment for the approved service location. The approval letter is sent to the provider's mailing address.

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12. What determines the effective date of provider enrollment?

The effective date of enrollment is the date a complete application is received by the Provider Enrollment Division (PED), which is identified on a notice issued to the provider to acknowledge the application was received.

For additional information on the effective date, review the ***Medi-Cal Provider Enrollment Effective Date Determination*** article.

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13. Can an applicant/provider submit a photocopy or a faxed copy of the application package?

A photocopy of the application package is acceptable; however, the signature must be an original. Stamped, faxed or copied signatures are not acceptable. Although the form may be photocopied, it is unlawful to alter it in any manner. If a mistake is made entering information on a form, line through the mistake and initial it. Do not use correction tape, white out, etc. to make corrections.

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PROVIDER NUMBER/NATIONAL PROVIDER IDENTIFIER (NPI)

1. How is a provider notified of application approval?

Providers receive a "Welcome to Medi-Cal" letter when the application is approved and entered into the Provider Master File. The letter is mailed to the provider's mailing address listed on the application. Approval letters contain the effective date of enrollment and the address at which the services are provided. However, rendering providers to a group are not individually notified, rather, correspondence is sent to the group's business address after the rendering provider has been added.

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2. What are the rules for using the provider number?

Each approved provider has agreed to abide by all program requirements published in the Medi-Cal provider manual.

No provider shall submit claims to the Medi-Cal program using any provider number other than that issued to the provider by the DHCS, or their assigned NPI number.

Provider agrees that it has no property right in or to its status as a provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that a provider may not assign its provider number, or any rights and obligations it has under a *Medi-Cal Provider Agreement* unless allowed as described in the ***Requirements and Procedures for Successor Liability*** article.

3. Who do providers contact regarding a lost provider number?

If a Medi-Cal provider number is lost, the provider must submit a *Medi-Cal Provider Number Verification Form* to PED. The request must be signed by the provider and include a photocopy of his or her medical license, and driver's license, or state-issued identification card.

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DEACTIVATION OF A PROVIDER

1. When can a provider number be deactivated without notification?

A provider number is deactivated when either:

- Warrants or documents mailed to the service or business address or the pay-to address were returned by the United States Postal Service as not deliverable; or
- A claim has not been submitted for reimbursement from the provider for one year.
- A Medi-Cal enrolled business is sold and the new owner (transferee) has been subsequently approved for enrollment.

Prior to deactivating a provider number for either of the first two reasons above, DHCS makes an attempt to contact the provider by telephone or mail.

If unable to make contact, DHCS is required to deactivate the provider number immediately without prior notice. For additional information about deactivation for returned mail please refer to W & I Code, Section 14043.62(a) for the full text of the statute and the ***Provider Guidelines*** section of the Part 1 manual.

For additional information about deactivation for non-participation, please refer to W & I Code, Section 14043.62 (a) *the Provider Guidelines* section of the Part 1 manual and the December *2003 Medi-Cal Update* article "Inactivation of Non-Participating Providers: Reminder."

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2. Can provider numbers be reactivated?

Submission of a complete application package specific to the provider type is required for provider number reactivation.

Deactivation due to DHCS sanctions is subject to specific restrictions. Detailed information is included with the written notification to the sanctioned provider.

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BILLING FOR SERVICES

1. When can providers start billing for services?

Prospective Medi-Cal providers must apply for and be enrolled in the Medi-Cal program, be assigned a provisional provider number and agree to conditions of participation before claim submission or payment can be made for services furnished to Medi-Cal recipients. Prior to approval of the application and issuance of a provider number, the applicant's decision to see Medi-Cal patients is at his/her own personal risk for payment.

Rendering providers cannot bill directly; it is the group that bills Medi-Cal for the services rendered by the providers enrolled in their group.

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2. Where can providers find answers to other billing questions?

For assistance with billing and claims, please contact the EDS Telephone Service Center at 1-800-541-5555 or visit the Medi-Cal Web site (**www.medi-cal.ca.gov**) and click the "Contact Medi-Cal" link. For the most current information regarding billing and claims submission, refer to the "Medi-Cal Newsroom" area on the Medi-Cal home page.

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If interested in applying for Electronic Funds Transfer (EFT), review the ***EFT Enrollment Authorization*** form. Complete and send a notarized EFT Enrollment Authorization form and a voided check to:

Attn: EFT Unit
EDS Corporation
P.O. Box 13029
Sacramento, CA 95813-4029

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PROVIDER TERMINATION

1. How do providers terminate their Medi-Cal enrollment?

A Medi-Cal provider may request to be deactivated by submitting a *Medi-Cal Supplemental Changes* (DHCS 6209) form.

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EMERGENCY ROOM SERVICES

1. What determines the effective date for Emergency Room Services?

The DHCS has created an exception for applicants who provide emergency room services or other services to Medi-Cal recipients who come to a hospital emergency room and are treated by practitioners who are required by contract with the acute care hospital or acute psychiatric hospital to treat those patients.

For information on determining the effective date for emergency room services, please review the ***Medi-Cal Provider Enrollment Effective Date Determination*** article.

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PURCHASE/SALE OF A MEDI-CAL ENROLLED BUSINESS

1. What is the process for buying a Medi-Cal enrolled business?

A provider number is not transferable pursuant to Title 22, CCR Section 51000.52(b), except when a transferee applicant meets the successor liability with joint and several liability requirements set forth in Title 22, CCR Section 51000.32. Therefore, without completion of the agreement, the transferor (seller) remains solely liable after the close of the sale, until such time that the transferee (buyer) becomes an enrolled provider. Should the buyer subsequently fail to become enrolled as a Medi-Cal provider, the seller continues to solely carry all liability to DHCS for all amounts paid for services, goods, supplies, or merchandise, provided directly or indirectly, to Medi-Cal beneficiaries.

If you purchase a Medi-Cal enrolled business and you have entered into a valid successor liability with joint and several liability agreement, you are considered to be a transferee applicant. "Transferee Applicant" means an individual or entity that joins a provider transferor's Medi-Cal provider agreement including the use of the provider number issued for that location when any of the following occur

(1) A sale or transfer of 50 percent or more of the assets owned by the corporation at the location for which a provider number was issued;

(2) A cumulative change in the person(s) with an ownership or control interest of 50 percent or more that has occurred since the information provided in the last complete application package approved for enrollment;

(3) When a new Taxpayer Identification Number is issued by the IRS;

(4) When the Board of Pharmacy requires a new site permit, pursuant to chapter 9 (commencing with Section 4000) Division 2 of the Business and Professions Code;

(5) A change of ownership as defined in Title 22, CCR Section 51000.6.

If you have any of the above circumstances and the transferor (seller) elects to complete a *Successor Liability with Joint and Several Liability Agreement*, you must submit to DHCS, within 35 days of the occurrence of any event listed above, a complete application package pursuant to Title 22, California Code of Regulations Section 51000.30.

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2. What is the process for selling a Medi-Cal enrolled business?

A provider number is not transferable pursuant to Title 22, CCR Section 51000.52(b), except when a transferee applicant meets the successor liability with joint and several liability requirements set forth in Title 22, Section 51000.32. Therefore, without completion of the agreement, the transferor (seller) remains solely liable after the close of the sale, until such time that the transferee (buyer) becomes an enrolled provider. Should the buyer subsequently fail to become enrolled as a Medi-Cal provider, the seller continues to solely carry all liability to the DHCS for all amounts paid for services, goods, supplies, or merchandise, provided directly or indirectly, to Medi-Cal beneficiaries.

If you sell a Medi-Cal enrolled business and you have entered into a valid successor liability with joint and several liability agreement you would be considered to be a transferor. As the transferor, upon the sale of the business, you may elect successor liability with joint and several liability by meeting both of the following conditions:

(1) By letter postmarked no later than five days after the occurrence of any event listed in Title 22, CCR Section 51000.30(b), the provider transferor and the transferee applicant shall submit to the DHCS the *Successor Liability with Joint and Several Liability Agreement* (DHCS 6217), signed and dated by both, which includes the following information:

- The legal name of the provider transferor which shall be the name currently on file with the IRS;
- Current provider number for the location affected;
- Fictitious business name of the transferee applicant, if applicable;
- The legal name of transferee applicant, which shall be the name currently on file with the IRS;

- Current provider number(s) of transferee applicant, if applicable;
- Fictitious business name of the transferee applicant, if applicable;

A statement signed and dated by both the provider transferor and the transferee applicant wherein they accept joint and several liability for all debt arising from the Medi-Cal provider agreement applicable to the location for which a provider number was issued by the DHCS.

(2) The transferee applicant shall submit to the DHCS within 35 days of the occurrence of any event listed in Title 22, CCR Section 51000.30(b), a complete application package pursuant to Title 22, Section 51000.30.

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3. Why should providers consider completing a *Successor Liability with Joint and Several Liability Agreement* (DHCS 6217)?

A provider number is not transferable (Title 22, Section 51000.52(b)), except when a transferee applicant meets the successor liability with joint and several liability requirements set forth in Title 22, Section 51000.32. Therefore, without completion of the agreement, the transferor (seller) remains solely liable after the close of the sale, until such time that the transferee (buyer) becomes an enrolled provider. Should the buyer subsequently fail to become enrolled as a Medi-Cal provider, the seller continues to solely carry all liability to the DHCS for all amounts paid for services, goods, supplies, or merchandise, provided directly or indirectly, to Medi-Cal beneficiaries.

"Successor Liability with Joint and Several Liability" means a provider transferor (seller) joins a transferee applicant (buyer) to its Medi-Cal agreement, including its rights to use the provider number issued for that location. Through this process, the transferor (seller) and the transferee (buyer) become jointly liable for all debts that are incurred for the period of time that it takes to determine if the transferee (buyer) will be issued his/her own new provider number and/or until the new number is issued. Completion of the form is elective on the part of the provider. However, if he/she elects to utilize this provision, he/she must strictly comply with its provisions.

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MISCELLANEOUS

1. Where do Medi-Cal recipients acquire a list of Medi-Cal providers?

Medi-Cal recipients need to contact their local county office of Health and Human Services for a list Medi-Cal providers in their county. For a listing of the local county offices, please visit the DHCS Web site and click the "Locate the Nearest County Office" link.

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2. Are substituting physicians required to apply as a Medi-Cal provider?

Medicaid Information Release MA01-19, *Procedure for Locum Tenens and Reciprocal Billing*, effective August 1, 2001, allows for physicians to bill for locum tenens using the following guidelines:

- Locum tenens is the practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though he/she performed them. These substitute physicians are generally called "locum tenens" physicians.
- Locum tenens occurs when the substitute physician covers for the regular physician during absences not to exceed a period of 90 continuous days.
- Reciprocal billing occurs when substitute physicians cover the regular physicians during absences and/or on an on-call basis not to exceed a period of 14 continuous days.

Procedure for locum tenens and reciprocal billing claims: In reimbursement for locum tenens/reciprocal billing the recipient's regular physician may submit the claim and receive payment for covered Medicaid services (including emergency visits and related services) provided by a locum tenens physician who is not an employee of the regular physician. Services for recipients are not restricted to the regular physician's office.

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